

# REGISTRATION FORM

**CLASS/WORKSHOP NAME:** \_\_\_\_\_

**CLASS/WORKSHOP DATE:** \_\_\_\_\_

Participant Name \_\_\_\_\_

Guardian's Name (if participant under 18yrs) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

## Who to contact in case of emergency

Name \_\_\_\_\_

Phone \_\_\_\_\_

Do you have any medical conditions for which you are currently receiving treatment? Or medication? Yes No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Do you have any pre-existing medical conditions? Yes No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Do you carry any medical insurance? Yes No

If so, insurance company or provider \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

(signature of guardian if participant under 18yrs)